FILED
AUG 28 1998
OFFICE OF THE CLERK
SUPREME COURT, U.S.

No. 97-1947, No. 97-1949, No. 97-2079

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1997

BEVERLY COMMUNITY HOSPITAL ASS'N, *Petitioner*,

v.

S. KIMBERLY BELSHÉ, Director of the California Dept. of Health Services, *Respondent*.

CALIFORNIA AMBULANCE ASS'N and CALIFORNIA MEDICAL ASS'N, et al., *Petitioners*,

v.

S. KIMBERLY BELSHÉ, Director of the California Dept. of Health Services, and DONNA E. SHALALA, Secretary, United States Dept. of Health and Human Services, *Respondents*.

RICHARD GILMORE, et al., *Petitioner*,

v.

S. KIMBERLY BELSHÉ, Director of the California Dept. of Health Services, and DONNA E. SHALALA, Secretary, United States Dept. of Health and Human Services, *Respondents*.

On Petition for Writ Of Certiorari To The United States Court of Appeals for the Ninth Circuit

---

BRIEF IN OPPOSITION TO PETITIONS FOR WRITS OF CERTIORARI

DANIEL E. LUNGREN
Attorney General
CHARLTON G. HOLLAND, III
Senior Assistant Attorney General
Counsel of Record
50 Fremont St., Room 300
San Francisco, CA 94105
Telephone: (415) 356-6309
Fax: (415) 356-6301
Counsel for State Respondent

42 pp

QUESTION PRESENTED

Is California's interpretation of 42 U.S.C. section 1396a(n) correct in light of the fact the Secretary of the Department of Health and Human Services shared that interpretation, that Congress ratified that interpretation by clarifying legislation and that the interpretation is consistent with the statutory scheme regarding qualified medicare beneficiaries?

TABLE OF CONTENTS

	Page
PREFACE	1
INTRODUCTION	1
SUMMARY OF ARGUMENT	2
STATEMENT OF THE CASE	2
STATUTORY AND REGULATORY BACKGROUND	2
1. Medicaid/Medi-Cal.	2
2. Medicare.	4
3. The QMB Provisions.	5
A. The QMB Program.	5
B. 1998: Expansion of the QMB Program	6
C. California's Implementation - Part A.	8
D. California's Implementation - Part B.	9
E. The Litigation.	10

TABLE OF CONTENTS, CONT'D

F. The Balanced Budget Act of 1997. 12

G. Wisdom comes eventually - Beverly and Paramount decisions in favor of the Secretary and California. 14

REASONS FOR THIS COURT NOT TO GRANT THE PETITIONS FOR CERTIORARI 16

1. Although California and the Secretary are correct in their interpretation of section 1396n(a) in the context of QMBs and the evolution of their eligibility for Medicaid, arguably the provisons are ambiguous so the Secretary's interpretation should have been given Chevron deference. 16

2. No review is appropriate because the circuits are not in confict over the merits of this case. 20

3. The "clarification" cannot be considered bogus by the argument that Congress shold have made the "clarification" as the

TABLE OF CONTENTS, CONT'D

Petitioners would have Congress do it. 20

4. There is no "conflict" in this Court's decisions over the issue of the proper deference to be given a Congress' effort to clarify the law. 22

5. Beverly and Paramount determined that the statutory role given to section 1396a(n) scheme was ambiguous and therefore weight should be given to the clarification by Congress. 25

6. Klein is not a ground for review under the facts of these actions. 26

7. No provider in California was promised payment by the state for crossover claims at 100% of what Medicare Providers charge. 28

CONCLUSION 30

TABLE OF AUTHORITIES

Page

Cases

Beverly Community Hospital Association, et al. v. Belshe 14, 15

California Medical Association v. Lackyer 117 Cal.App.3d 551 (1981) 28

Chevron U.S.A., Inc. v. Nat'l Resources Defense Council 467 U.S. 837 (1984) 18, 26

Dameron Physicians Medical Group, Inc. v. Shalala 961 F. Supp. 1326 (N.D.Cal. 1997) 11

Gwaltney of Smithfield, Ltd. v. Chesapeake Bay Fdn., Inc. 484 U.S. 49 (1987) 24

Haynes Ambulance Service v. Alabama 36 F.3d 1074 (11th Cir. 1994) 10

Loving v. United States 517 U.S. 748 (1996) 23

Mackey v. Lanier Collection Agency & Serv. 486 U.S. 825 (1988) 24

McCreary, M.D., et al. v. Offner, et al. 1 F. Supp. 2d 32 (D.D.C. 1998) 15

TABLE OF AUTHORITIES, CONT'D

New York City Health & Hosp. Corp. v. Perales
954 F.2d 854 (2d Cir.), cert. denied,
113 S.Ct. 461 (1992) 10

Paramount Health Systems v. Wright
138 F.3d 706 (7th Cir. 1998) 14, 25, 26

Pennhurst State School & Hosp. v. Halderman
451 U.S. 1, 17 (1981) 17

Pennsylvania Medical Soc'y v. Snider
29 F.3d 886 (3d Cir. 1994) 10

Plant v. Spendthrift Farm, Inc.
514 U.S. 211 (1995) 27

Public Employees Ret. System v. Betts
492 U.S. 158 (1989) 24

Red Lion Broadcasting Co. v. FCC
395 U.S. 367 (1969) 22, 23

Rehabilitation Ass'n of Virginia v. Kozlowski
42 F.3d 1444 (4th Cir.)., 2451-1452
cert. denied, 116 S.Ct. 60 (1995) 10

Samuel v. California Department of Health Services
(N.D. Calif. 1983) 570 F.Supp. 566, 569
as modified 572 F.Supp. 273 9, 10

South Dakota v. Yankton Sioux Tribe
118 S. Ct. 789 (1998) 24

TABLE OF AUTHORITIES, CONT'D

Thomas Jefferson University v. Shalala
512 U.S. 704 (1994) 18

United States v. Klein
(80 U.S.) 128 (1872) 26, 27

United States v. Sioux Nation
448 U.S. 371 (1980) 27

Statutes

California Welfare and Institutions Code

14109.5 9, 30

42 United States Code

§ 1395 4
§ 1395c-1395i-4(1995) 4
§ 1395e 5
§ 1395j 5
§ 1395w-4(g)(3)(A) 8
§ 13951(a)(1) 5
§ 13951(b) 5
§ 1396a(a)(10)(E) 18, 19
§ 1396(a)(10)(E)(i) 5, 7
§ 1396a(a)(13)(A) 9
§ 1396a(30)(A) 4
§ 1396a(n) 2, 11, 12, 15-21, 22
§ 1396a(n)(1) 21
§ 1396a(n)(2) 21, 22
§ 1396c 3
§ 1396d(p)(1) 8

TABLE OF AUTHORITIES, CONT'D

§ 1396d(p)(1)(C) 7
§ 1396d(p)(3) 6, 18

Regulations

42 Code of Federal Regulations

409.80 5
433.139(b)(1) 4

Public Laws

Pub.L. No.99-509, § 9403, 100 Stat. 2053-2056 5, 6
No. 100-360; § 301(a)(1), 102 Stat. 748 7
No. 101-239, § 6102, 103, Stat. 2106 (1989) 8
No. 100-647, § 8434(a), 102 Stat. 3342, 3805 8
§ 9403(a)(3), 100 Stat. 2053 5
No. 89-97, 79 Stat. 291 (1965) 3
PL 105-33, 111 Stat. 251, § 4711 (1997) 9, 13

Other Authorities

H.R. Conf. Rep. No. 1104, 100th Cong. 2d Sess. (1988) reprinted in 1998 U.S.C.C.A.N. 5048, 5344 8

H.R. Rep. No. 100-105(II), 100th Cong., 2d Sess. 59 (1988) reprinted in 1988 U.S.C.C.A.N. 857, 882, 884 6, 7

TABLE OF AUTHORITIES, CONT'D

H.R. Rep. No. 247, 101st Cong., 1st Sess. 364 (1989) reprinted in 1989 U.S.C.C.A.N. 1906, 2090 8

S. Rep. No. 146, 99th Cong., 2d Sess. 1, 312 (1986) reprinted in 1986 U.S.C.C.A.N. 42, 279 4

H.R. Conf. Rep. No. 105-217, 105th Cong. 1st Sess. 870-871 reprinted in 1997 U.S.C.C.A.N. 176, 491-492 14

PREFACE

S. Kimberly Belshé, Director ("California") of the Department of Health Services of the State of California hereby files this Brief in Opposition to the petitions for writs of certiorari filed by the Petitioners in California Ambulance Ass'n and California Medical Ass'n v. S. Kimberly Belshé et al., No. 97-2079 (herein "Associations"), Richard Gilmore, M.D., et al. v. Donna E. Shalala, et al., No. 97-1949 (herein "Gilmore", and Beverly Community Hospital Ass'n, et al. v. S. Kimberly Belshé. No. 97-1947 (herein "Beverly"). The Secretary of the United States Department of Health And Human Services will be refereed to as the "Secretary."

INTRODUCTION

The brief in opposition filed by California to the petitions for writ of certiorari filed by the three Petitioners is combined because the statutes, cases and issues in question in these petitions are essentially identical. Therefore, no purpose would be served by filing separate, identical briefs in opposition to each petition.

California does not dispute the jurisdictional statements (California Ambulance Ass'n, p. 1, Gilmore, p. 1, Beverly, p. 1), the constitutional provisions and statutes involved, (California Ambulance Ass'n, p. 1, Gilmore, p. 1, Beverly, p. 1), set forth in each petition. California does not dispute the description by each petitioner of the sequence of events in the trial court and the Ninth Circuit. (Gilmore, p. 8-10, California Ambulance Ass'n, p. 8-10, Beverly, p. 2-5,) California does not agree with the questions presented by the Petitioners.

SUMMARY OF ARGUMENT

The petitions do not state any compelling reason under Rule 10 for this Court to grant certiorari. There is no conflict among the circuits because the two circuit decisions after the enactment of section 4714 reached the same result. California and the Secretary are correct in their interpretation of the role section 1396a(n) plays in the payment permitted the states to providers regarding crossover claims. It is not convincing to argue that Congress did not really "clarify" prior legislation because Congress did not narrowly make the clarification but did its best to put the issue at rest. This Court has a reasonable and venerable rule regarding the weight it gives to Congress's clarification of statutory policy, which was applied properly by both circuits and which does not need further elaboration, and which is not in conflict with any other maxim of statutory interpretation. Whatever life the Klein decision might have, this action is not the place to explore its vitality because Congress did not create a rule of decision that would bind the judiciary. Finally, in California no provider under Medicaid had a reasonable expectation that it would receive 100% of the amount it charged for the services it rendered to the beneficiaries of the Medicaid Program who are the subject of this action.

STATEMENT OF THE CASE

STATUTORY AND REGULATORY BACKGROUND

1. Medicaid/Medi-Cal.

The Medicaid Act, Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., was enacted by Congress in 1965. Medicaid is a need-based cooperative federal and

state cost sharing venture that enables each state "as far as practicable under the conditions in such State," to provide necessary medical assistance to families and individuals with insufficient income and resources. See, Pub. L. No. 89-97, 79 Stat. 286 (1965), as amended, 42 U.S.C. 1396 et seq. A state is not required to participate in the Medicaid program, but if it chooses to participate it must comply with the Medicaid Act and its implementing regulations. 42 U.S.C. 1396c.

Under Medicaid, each state has a fee schedule or methodology that establishes a rate for every item or service covered under the state's Medicaid plan. California's Medicaid rates are almost always less than the allowable charge for services under Medicare. Participating providers must accept the Medicaid payment, together with any nominal co-payment obligations, as payment in full for services and amounts covered under the state plan.

The methods, procedures and payment levels for Medicaid services must be under 42 U.S.C. § 1396a(30)(A):

> "as necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

Therefore, during the period covered by this litigation, the states were obligated to maintain Medicaid rates at a level sufficient to attract sufficient providers to

provide items and service to the relevant patient (including the QMB) population. The Petitioners (and Amicus) do not contend that the level of the Medicaid rates is inconsistent with section 1396a(30)(A).

Medicaid is the payer of last resort, which is to say that "other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." S. Rep. No. 146, 99th Cong., 2d Sess. 1, 312 (1986), reprinted in 1986 USCCAN 42, 279. See, 42 U.S.C. 1396a(a)(25). The Secretary's regulations require the states to reimburse a provider only to the extent that the state's Medicaid rate exceeds the third-party payment. 42 C.F.R. 433.139(b)(1). The Secretary views Medicare as a third party insurer under these regulations.

2. Medicare.

Enacted in 1965, Title XVIII of the Social Security Act is commonly known as the Medicare Act. See, Pub. L. No. 89-97, 79 Stat. 291 (1965), as amended, 42 U.S.C. 1395 et seq. Individuals who are at least 65 years of age or disabled (and meet certain other eligibility requirements) are automatically covered in Part A of the Medicare program, which provides reimbursement for inpatient hospital care and related post-hospital, home health and hospice care for aged and disabled beneficiaries. 42 U.S.C. 1395c-1395i-4 (1995). Under Part A, the federal government pays a health care provider's reasonable cost for covered services, less deductibles and coinsurance. Medicare beneficiaries who receive Part A services are responsible for paying "deductibles" (a fixed and limited amount of money toward the charge of hospital care) and "coinsurance" (a percentage of reasonable cost for each day of care after the first sixty

days). Some individuals also pay a premium. 42 U.S.C. § 1395e; 42 C.F.R. § 409.80. These are referred to herein as "Medicare cost-sharing amounts."

Part B is a voluntary insurance program pursuant to which eligible individuals may purchase supplementary insurance for hospital out-patient services, physician services, and other medical services not covered under Part A. 42 U.S.C. 1395j; 42 U.S.C. 1395l(a)(1); 42 U.S.C. 1395l(b).

Generally the federal government pays 80% of the allowable charges for Medicare beneficiaries who receive Part B services. The beneficiaries are responsible for paying deductibles (a fixed and limited amount), and coinsurance or copayments (a percentage of the reasonable value of the service). 42 U.S.C. § 1395e; 42 U.S.C. § 1396d(p)(3). The amounts beneficiaries are responsible for are referred to above and throughout - as with Part A - as "Medicare cost-sharing amounts."

3. The QMB Provisions.

A. The QMB Program.

Between 1967 and 1986, states were required to pay cost-sharing only on behalf of persons eligible for both programs. In 1986, Congress broadened the class of persons eligible for such coverage beyond these dual eligible. Pub.L. No. 99-509, §9403, 100 Stat. 2053-2056. The 1986 amendments provided that "at the option of a State" the State Plan could "provide for making medical assistance available for medicare cost-sharing" for "qualified medicare beneficiaries." *id.* §9403(a)(3), 100 Stat. 2053.[1] (42 U.S.C. § 1396(a)(10)(E)(i).)

---

1. At the time, QMB's were defined as persons (1) who were eligible for Medicare Part A but not otherwise eligible for Medicaid,

The states' obligations with regard to this new category of individuals were addressed in two subsections of section 9403. Section 9403(c)(2) provided that "the medical assistance made available to a qualified medicare beneficiary * * * shall be limited to medical assistance for medicare cost-sharing * * * subject to the provisions of subsection (n) [of this section]." Pub. L. No. 99-509, § 9403(c), 100 Stat. 2054 (codified in clause (VIII) in the matter following 42 U.S.C. § 1396a(a)(10)(F)) (emphasis supplied). The new Section "n," -- Section 9403(e) of the Public Law, (codified at 42 U.S.C. 1396a(n)) -- was entitled "Payment Amounts." It specified that states "may" provide for payment of Medicare cost-sharing in an amount "that results in the sum of such payment amount and any amount of payment made under [Medicare] * * * exceeding the amount that is otherwise payable under the State [i.e. Medicaid] plan * * *." Id. § 9403(e), 100 Stat. 2055. Thus, Congress expressed its intention that states not be required, although they might choose, to pay coinsurance on behalf of QMBs in amounts that exceeded the charges "otherwise payable" under the state's approved Medicaid plan.

B. 1998: Expansion of the QMB Program

The 1986 amendments, allowing states to pay cost-sharing for pure QMBs, had a limited practical effect: By 1988, only one state had chosen to purchase Part B Medicare for pure QMBs. H.R. Rep. No. 100-105(II), 100th Cong., 2d Sess. 59 (1988), *reprinted in* 1988 U.S.C.C.A.N. 857, 882. It was in 1988 that Congress for

---

(2) whose income did not exceed an amount set by the state but not more than 100% of the poverty line, and (3) whose resources did not exceed the Supplemental Security Income (SSI) program's maximum. *id.* §9403(b) (42 U.S.C. § 1396d(p)(1).)

the first time mandated that states make medicare cost-sharing available to persons not otherwise eligible for Medicaid assistance, *i.e.*, to pure QMBs. Pub. L. No. 100-360, § 301(a)(1), 102 Stat. 748 (deleting "at the option of the State" from 42 U.S.C. § 1396a(a)(10)(E)(i)). In the same bill that Congress thus first mandated coverage of pure QMBs, it also expanded the pool of those eligible to be QMBs by doubling the amount of resources an individual could own without losing QMB status. *Id.* § 301(c)(2) (codified at 42 U.S.C. §1396d(p)(1)(C)).

When it imposed these new obligations on the states, Congress was aware of the prior, practical construction of the law that states had discretion whether to make cost sharing payments over the Medicaid fee amount:

> It is the understanding of the Committee that, with respect to dual Medicaid-Medicare eligible, some States pay the coinsurance even if the amount Medicare pays for the service is higher than the State Medicaid payment rate, while others do not. Under the Committee bill, States would not be required to pay the Medicare coinsurance in the case of a bill where the amount reimbursed by Medicare -- i.e., 80 percent of the reasonable charge -- exceeds the amount Medicaid would pay for the same item or service. However, if a State chooses to pay some or all of the co-insurance in this circumstance, Federal matching funds would, as under current law, be available for this cost.

H.R. Rep. No. 105(II), 100th Cong., 2d Sess. 61 (1988), *reprinted in* 1988 U.S.C.C.A.N. 857, 884.

Later in 1988, Congress changed the statutory definition of QMB to its current form, so that now it

includes both pure QMBs and dual eligible. Pub. L. No. 100-647, § 8434(a), 102 Stat. 3342, 3805. The accompanying House Conference Report explained that all Medicare-eligible persons with income and resources under the limits set by 42 U.S.C. 1396d(p)(1), are to be considered QMBs, "whether or not they are otherwise eligible for Medicaid." H.R. Conf. Rep. No. 1104, 100th Cong. 2d Sess. (1988), *reprinted in* 1988 U.S.C.C.A.N. 5048, 5344.

Finally, in 1989, Congress amended the Medicare Act to require that physicians treating QMBs accept assignment from Medicare, thereby precluding the billing of QMBs in excess of the fee schedule amount set by Medicaid. Pub. L. No. 101-239, § 6102, 103 Stat. 2106 (1989) (codified at 42 U.S.C. § 1395w-4(g)(3)(A)). In so doing, the House Report considered the current practices of the States, as approved by the Secretary, regarding Medicaid payment of coinsurance for QMBs and ratified this practice: "The Medicaid programs typically pay the Medicare coinsurance only to the extent that their payment, plus the Medicare payment, does not exceed what the Medicaid program would pay for the service in question * * *. The Committee bill * * * does not change the current policy regarding the amount which a Medicaid program must reimburse on such claims. H.R. Rep. No. 247, 101st Cong., 1st Sess. 364 (1989), reprinted in 1989 U.S.C.C.A.N. 1906, 2090 (emphasis added).

C. California's Implementation - Part A.

California's policy regarding reimbursement for providers of inpatient hospital services has been consistent since the enactment of California Welfare & Institutions Code § 14109.5 (effective January 1, 1982). However,

California's ability to effectuate the policy has been dependent on its Medicaid agency's, the Department of Health Services, ability to identify comparable services, which initially was not possible with hospital inpatient services. In 1992, section 14109.5 was amended to direct the Department to look toward Medicare itself for establishing rates for comparable hospital inpatient services, which the Department did pursuant to 42 U.S.C. § 1396a(a)(13)(A) ("the Boren Amendment") (now repealed, P.L. 105-33, 111 Stat. 251, sec. 4711 (1997)). When the Department had completed its required Boren Amendment analysis, it concluded that the amounts paid - as contrasted with the rates charged by the providers - by Medicare were reasonable and adequate reimbursement for the providers of inpatient hospital services to beneficiaries eligible for both Medicare and Medi-Cal. Accordingly, in 1994 the Department adopted the Medicare level of payment as its standard for reimbursement for services rendered to beneficiaries who are eligible for both Medicare and Medi-Cal.

D. California's Implementation - Part B.

Prior to January 1, 1982 California paid all deductibles and coinsurance costs on behalf of all enrollees under the Part B buy -in agreement. California's buy-in agreement was amended and approved by the Secretary, effective January 1, 1982, capping payment under the buy-in agreement to the maximum Medi-Cal (Medicaid) payment for the same service. (Samuel v. California Department of Health Services (N.D. Cal. 1983) 570 F.Supp. 566, as modified, 572 F.Supp. 273.)

Samuel held that under a buy-in agreement when California pays the Part B premiums the Medicare Part B coverage thereby becomes part of the Medi-Cal program's

scope of benefits. By holding that a health care provider that accepts a crossover beneficiary therefore must accept the patient as a Medi-Cal patient and by prohibiting providers from seeking further reimbursement from beneficiaries, the Court approved California's rate limitation for Part B services. (Samuel at p. 573.)

Hence, notwithstanding the expansion in the class of beneficiaries a state may include in its Medicaid state plan and buy-in agreement, Samuel holds that the program remains a Medicaid program pursuant to which a state may purchase some or all of the benefits provided through Medicare Part B (and by extension Part A) and is not required to reimburse providers at higher than the Medicaid rate.

E. The Litigation.

Once Congress passed the 1988 legislation, providers saw an opportunity to close the gap between what had always been a difference in payment and which had been approved in California under Samuel. Four Circuit Courts held, with dissents and with different views on the meaning of 1396a(n) and the policy motivating Congress in 1986 and 1988, that the providers were entitled to the higher Medicare rate. Rehabilitation Ass'n of Virginia v. Kozlowski, 42 F.3d 1444 (4th Cir.), (Niemeyer, J. dissenting), cert. denied, 116 S. Ct. 60 (1995) ("Kozlowski"); Haynes Ambulance Service v. Alabama, 36 F.3d 1074 (11th Cir. 1994) ("Haynes"); Pennsylvania Medical Soc'y v. Snider, 29 F.3d 886 (3d Cir. 1994) ("Snider"); New York City Health & Hosp. Corp. v. Perales, 954 F.2d 854 (2d Cir.), (Cardamone, J., dissenting) (cert. denied, 113 S. Ct. 461 (1992) ("Perales").

Later, in California, Judge Letts of the Central District agreed with the result of these decisions and entered judgment for the providers in the three cases in this action. In the Northern District, Judge Legge in Dameron Physicians Medical Group, Inc. v. Shalala, et al., 961 F.Supp. 1326 (N.D.Cal. 1997) reached the opposite conclusion:

> "In the absence of a clear answer in the statutory language, and in light of the United States Supreme Court's decision in Chevron and the Ninth Circuit's decision in Stephenson, this court must accept the defendants' interpretation of the statutes at issue. California may cap its payments at the Medi-Cal maximum levels." (Id. at 1333.)

The district courts in Snider, Haynes, and Perales had agreed also with the position taken by California and the Secretary.

Aside from the conflicting district court decisions, the various positions taken in the opinions justify the rule that deference should be given to the Secretary when the statutory scheme is unclear. In Snider, the court concluded that Congress' policy to make the crossover program mandatory was to force the states to expend a projected windfall on the elderly poor. (Id. at 902) Whether that intent was true, there was no legislative history Congress wanted the money to go to providers. In Perales, the court concluded Congress' policy was to prevent a two tiered reimbursement system for crossover beneficiaries. (Id. at 858-859.) However, the Perales court could only justify Congress' policy based upon tenuous inferences drawn from Congress' 1965 policy relating to the difference between private pay and

Medicare patients. (Ibid.) Haynes adopted Snider in its analysis. In Kozlowski, the court held, with Justice Niemeyer offering a different analysis, that the permissive language in section 1396a(n) is limited to the option the states possessed prior to 1988 to pay a higher Medicare benefits to "pure" QMBs than to dual eligible. The irony, in light of the Petitioners' argument that any attempt at clarification of policy by Congress should be ignored by the judiciary or given little weight, is that the circuits justified their interpretation of QMB reimbursement scheme based upon a search for the policy of Congress.

F. The Balanced Budget Act of 1997.

Given the litigation that developed regarding Congress's intention in the 1988 legislation, the welter of conflicting district and court of appeals decisions, and the conflict between the providers, on the one hand, and the states and Secretary on the other, Congress enacted section 4714 of the Balanced Budget Act of 1997 ("BBA") (P.L. 105-33, 111 Stat. 251, eff. August 5, 1997) entitled a "clarification regarding state liability for medicare cost-sharing." Congress amended section 42 U.S.C. section 1396a(n) to read as follows:

> (2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred related to payment for deductible, coinsurance, or copayments for medicare cost sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary.

Congress also provided that its clarification applied to existing litigation:

> (c) EFFECTIVE DATE.--The amendments made by this section shall apply to payment for (and with respect to provider agreements with respect to) items and services furnished on or after the date of the enactment of this Act. The amendments made by subsection (a) shall also apply to payment by a State for items and services furnished before such date if such payment is subject of a law suit that is based on the provisions of section 1902(n) and 1905(p) of the Social Security Act and that is pending as of, or is initiated after, the date of the enactment of this Act."

The Committee of Conference statement describes Congress understanding of pre-BBA law:

> "State Medicaid programs are required to pay Medicare cost-sharing charges for individuals who are beneficiaries under both Medicaid and Medicare, (dual eligible) and for qualified Medicare beneficiaries (QMBs). QMBs are individuals who have incomes not over 100% of the poverty level and who meet specified resources standards.) The amount of the required payment has been the subject of some controversy.State Medicaid Programs frequently have lower payment rates for services than the rates that would be paid under Medicare. Program guidelines permit states to pay either (1) the full Medicare deductible and coinsurance amounts or (2) cost-sharing charged only to the extent that the Medicare provider has not

received the full Medicaid rate for an item or service. Some courts have forced state medicare programs to reimburse Medicare provider to the full Medicare allowable rates for services provided to QMBs and dually eligible individuals." (See H. Conf. Rep. No 105-217, 105th Cong. 1st Sess. 870-870 reprinted in 1997 U.S.C.C.A.N 176, 491-492)

The report then concluded that the amendment:

"Clarifies that state Medicaid programs may limit Medicare cost-sharing to amounts that, with the Medicare payment, do not exceed what the state' Medicaid program would have paid for such service to a recipient who is not a QMB. Specifies that the Medicare payment plus the state' Medicaid payment will be considered payment in full and the QMB will not be liable for payment to a provider or managed care entity. Additionally provides that any sanction for excess charges that may be imposed on a provider or managed care entity under Medicare may be imposed for making excess charged under Medicaid. Applies to items and services furnished on or after the date of enactment. In the case of payment that is subject to a law suit that is pending as of the date of enactment, or initiated after the date of enactment, applies to items and services furnished before the date of enactment." (Ibid.)

G. Wisdom comes eventually - Beverly and Paramount decisions in favor of the Secretary and California.

The Ninth Circuit decided the case that is the subject of these petitions, Beverly Community Hospital Ass'n v. Belshe, 132 F.3d 1259 (9th Cir. 1997) and the Seventh Circuit decided Paramount Health Systems, Inc. v. Wright, 138 F.3d 706 (7th Cir. 1998). Both of these courts recognized that Congress' intent pre-BBA was unclear in relation to QMBs and that, giving deference to Congress' expression of clarification in section 4714, weighed the balance in favor of the interpretation taken by California and the Secretary.

In Beverly the court pointed out that "Section 1396a(n) is a superb example of the baffling nature of [the Medicaid and Medicare acts]." (Id. at 1266.) "It has shown itself to be particularly resistant to a single simple interpretation, and hence particularly in need of clarification." (Ibid.) In Paramount, although the court mused whether section 4714 really was a proper clarification, eventually it concluded the place of section 1396a(n) in Congress' scheme of reimbursement was sufficiently ambiguous to accept the interpretation of California and the Secretary, to wit:

> The Act is a hopeless muddle so far as [QMB] reimbursement is concerned, and while it seems to us that [the health providers have] the better interpretation, there is sufficient ambiguity to require us to defer to the government." (Id. at 711.)

Beverly and Paramount have been followed in McCreary, M.D. et al. v. Offner, et al., 1 F.Supp. 2d 32 (D.D.C. 1998) in which Judge Friedman of the District of Columbia District Court held:

> Whether one scrutinizes the clarifying claims of Section 4714 with a harsher gaze or not, one thing is clear: the law regarding state liability to pay for the health services provided to QMBs has never been crystal clear. Section 4714 has certainly provided clarification where it was needed. For this reason, the Court concludes that applying Section 4714 retroactively, as Congress directed, is not impermissible under the Constitution." (Emphasis supplied.) (Id at 49.)

The question now is whether this Court should accept the Petitioners' invitation to enter this "muddle" and resolve the issue.

REASONS FOR THIS COURT NOT TO GRANT THE PETITIONS FOR CERTIORARI

1. Although California and the Secretary are correct in their interpretation of section 1396n(a) in the context of QMBs and the evolution of their eligibility for Medicaid, arguably the provisons are ambiguous so the Secretary's interpretation should have been given Chevron deference.

In essence, the Petitioners are petitioning this court on their interpretation of section 1396a(n) as it existed pre-BBA. Whatever section 4714 did, it affirmed Congress' policy that states do not have to pay providers of Part A and B services to QMBs at the

Medicare rate. Accordingly, the Petitioners are contending for an interpretation of section 1396a(n) and a basic policy position about reimbursement that Congress is unwilling to support.

California is correct regarding its interpretation of its reimbursement duty under Medicaid. Medicaid is the payor of last resort. The statutory scheme is that all other sources of payment must be exhausted before the Medicaid program is available for payment. California has been consistent in this scheme. Until Judge Letts issued his order in 1996, California's Medicaid program did not reimburse providers more than the Medicaid rate for QMBs.

Part A was different but only because a difficulty existed in determining for hospital services what was the Medicaid rate in relation to the Medicare rate. Once that Medicaid rate was established in 1994 by California's Medicaid agency, Part A was applied consistently with reimbursement under Part B.

It is clear that Congress intended in 1988 to mandate the states to include QMBs as part of the Medicaid program. Few states had voluntarily joined - unquestionably owing to the financial burden that joinder would impose. In that light, without a clear expression of intent, it does not make sense for Congress to both mandate QMBs into the Medicaid program and to burden the states with additional financial costs - which they had been unwilling to assume - without a clear expression that the providers would benefit from this change in the law.

To the contrary, Congress left section 1396a(n) untouched in 1988 in order to preserve the states

flexibility in responding to this mandatory addition to the Medicaid program. As we pointed out above, Medicaid is a jointly funded federal-state program. As a joint spending program, "if Congress intends to impose a condition on the grant of federal moneys" to the states, "it must do so unambiguously." Pennhurst State School & Hosp. v. Halderman, 451 U.S. 1, 17 (1981) (citations omitted). Only if courts "insist[] that Congress speak with a clear voice" can the states "exercise their choice knowingly, cognizant of the consequences of their participation." (*Id.*) Although California believes Congress was clear in the past regarding its reimbursement duty to providers regarding section 1396a(n), at the minimum the provision is ambiguous and should not be interpreted against her under Pennhurst. In light of the Secretary's support for California's position, the Secretary's interpretation should be conclusive under Chevron U.S.A. Inc. v. National Resources Defense Council, Inc., 467 U.S. 837, 842-43 (1984).

The circuits could reject the Secretary's construction of the statute only if they were able to conclude that "Congress has directly spoken to the precise question at issue"; otherwise, "if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." Chevron, 467 U.S. at 842-43 (1984) (emphasis supplied) (footnote omitted). The Kozlowski majority acknowledged that the Medicaid and Medicare acts were "among the most impenetrable texts within human experience" and provide "dense reading of the most tortuous kind." 42 F.3d at 1444. In this "'complex and highly technical regulatory program,'" deference "is all

the more warranted." Thomas Jefferson University v. Shalala, 512 U.S. 704, 710 (1994) (citation omitted).

Section 1396a(a)(10)(E) of Title 42 provides that a state plan "must" make Medicaid funds available for medical cost-sharing on behalf of QMBs. "Cost-sharing" is separately defined as including Part A deductibles and coinsurance. 42 U.S.C. 1396d(p)(3). The Petitioners read Section 1396a(a)(10)(E) and Section 1396d(p)(3) together as making it mandatory on the states to pay 100% of all reasonable charges for QMBs.

Yet if the Petitioners are correct in their reading, Section 1396a(n) -- which is entitled "Payment Amounts" and permits (but does not require) states to make payments in excess of the Medicaid ceiling -- would be entirely unnecessary, even though this section was enacted at the very same time, and in the same piece of legislation that created Section 1396a(a)(10(E).

Apart from this anomaly, the Petitioners' statutory reading is flawed. It is argued that, having used the word "must" in §1396a(a)(10)(E), Congress made mandatory the obligation on states to pay cost-sharing. The statutory language the Petitioners rely upon, however, does not mandate payment of coinsurance and deductibles in full, as the Petitioners would have it. Section 1396d(p)(3) is not addressed to the subject of payment amounts. It merely states that in certain circumstances the state is obliged to pay premiums and deductibles and coinsurance, without specifying whether the costs are to be paid in full, or are subject to the standard Medicaid limits.

Because Section 1396a(a)(10)(E) does not specify the amount of money a state is obliged to pay as coinsurance for QMBs and dual eligible, the Court must look elsewhere in the statute. Finding the relevant section is not hard: 42 U.S.C. 1396a(n), which was enacted in the same piece of legislation as Section 1396a(a)(10)(E), is entitled "Payment Amounts," and gives the states leave to limit reimbursement of coinsurance and deductibles to the ceiling set by Medicaid -- or in the alternative to pay the full 100%, as the state wishes. Section 1396a(n) is the answer to the question posed by this lawsuit -- not Section 1396a(a)(10)(E).

The two provisions may be reconciled by reading Section 1396a(a)(10)(E) to require that funds be available for coinsurance and deductibles only to the extent that a Medicaid plan under Section 1396a(n) provides for payments in excess of Medicare payments.

2. No review is appropriate because the circuits are not in confict over the merits of this case.

Rule 10.1(a) sets forth that reason for granting a petition for certiorari might be "[w]hen a United States court of appeals has rendered a decision in conflict with the decision of another United States court of appeals on the same matter." The Petitioners' fundamental ground for requesting certiorari from this court is that there is a conflict among the circuits because the court of appeals in Paramount and Beverly reached different conclusions than Kozlowski, Haynes, Snider, and Perales. This argument is fallacious. When the four cases were decided, the courts did not have the clarification provided by Congress. We do not know

what result these courts would have reached with this additional factor in mind. In any event, the two circuits post-section 4714 are consistent in holding that, when taken with the clarification from Congress, the better decision was that section 1396a(n) did authorize the states to make payments to providers at an amount less than the Medicare payment rate. For this reason, there is no conflict which warrants review by this court.

3. The "clarification" cannot be considered bogus by the argument that Congress shold have made the "clarification" as the Petitioners would have Congress do it.

The Petitioners argue strongly that the "clarification" of Congressional intent is bogus - that the Paramount and Beverly courts should have found that Congress did not clarify the law - it substantially changed the law. It is clear that Congress did intend to clarify the law. The title to section 4714(a) states that the amendment is a "clarification." Section 4714(c) states that the amendment relates back to "items and services furnished before [the date of the enactment of this Act] if such payment is the subject of a law suit that is based on the provisions of sections 1902(n) and 1905(p) of the Social Security Act and that is pending as of, or is initiated after, the date of enactment of this Act." The House Committee report recognizes a reimbursement gap between what the states and Medicare pays and expressly states that section 4714 "clarifies that state Medicaid program may limit Medicare cost-sharing to amounts that, within the Medicare payment, do not exceed what the state's Medicaid program would have paid for such service to a recipient who is not a QMB."

The Petitioners press several arguments, in the face of Congress' explicit statement of clarification, to demonstrate that no clarification exists. They argue section 1396a(n) is unchanged in text as section 1396a(n)(1), that the cap is placed in a new subsection 1396a(n)(2), that three new provisions were enacted (i.e., that Medicare is "payment in full," that providers have no recourse against the beneficiaries, and that a third party may be liable for the payment gap) and that a clarification does not need an "effective" date. They also argue that it is probative that the "clarification" appears in a budget measure.

Petitioners' arguments beg the question. Congress' clarification tracks the interpretation California and the Secretary have taken regarding section 1396a(n). If Congress had not expressly stated it was clarifying the law, Petitioners' arguments might have some merit. Petitioners argument is that for Congress to have a true clarification it must legislate narrowly on the issue. Presumptively, if Congress had only enacted section 1396a(n)(2) and called it a clarification, Petitioners would have no complaint. The fact that Congress added provisions to make its original intent more workable or clear should not detract from its attempt to clarify the law.

The fact that section 4714 was enacted in a budget provision makes sense. The dispute is not over the coverage of benefits to poor people. The dispute is between providers, and the states and the federal government over the rates of reimbursement. The need for an effective date is reasonable. In the Snider, Perales, Haynes, and Kozlowski circuits, the providers are no longer to be paid at the Medicare rate. Congress wisely limited the impact of the clarification to

circuits which had pending lawsuits, not those in which the rights of the providers had become vested by virtue of a final judicial decision.

4. There is no "conflict" in this Court's decisions over the issue of the proper deference to be given a Congress' effort to clarify the law.

The Petitioners argue that a conflict exists between this Court's rule regarding the deference to be given Congressional enactments which purport to clarify the effect of prior law. In fact, that conflict does not exist or, if it does, it is hardly sufficient to justify this Court granting writs of certiorari to review these cases.

In Red Lion Broadcasting Co. v. FCC, 395 U.S. 381 (1968) this Court was confronted with a challenge by a licensee of the Federal Communications Commission to the "fairness doctrine." The FCC had interpreted the underlying statute by regulation which set forth the rule. Thirty years later Congress enacted a statement of the FCC rule under circumstances which the Court found to be a clarification of existing law. In such a case, this Court held:

> "Subsequent legislation declaring the intent of an earlier statute is entitled to great weight in statutory construction. And here this principle is given special force by the equally venerable principle that the construction of a statute by those charged with this execution should be followed unless there are compelling indications that it is wrong, especially when Congress has refused to alter the administration construction. Here, the

> Congress has not just kept its silence by refusing to overturn the administrative construction, but has ratified it with positive legislation. (Id. at 380-382 [footnotes omitted].)

This announcement of statutory construction in Red Lion Broadcasting fits the facts of these cases like a glove. The Secretary held to a long standing position that the states did not have to pay the full cost sharing amounts. Congress never altered the Secretary's interpretation. Later, Congress ratified that administrative construction with positive legislation by enacting section 4714. This Court in Red Lion Broadcasting pointed out that this principle of statutory construction was "venerable." (Id. at 381, n. 8.)

In Loving v. U.S., 517 U.S. 748, 116 S.Ct. 1737 (1996) this court repeated this "venerable" principle with approval but in a fact situation less applicable to the facts before this court.

The Petitioners create a false dilemma - that a conflict exists between two lines of authority of this Court and that only a resolution of that conflict in these cases can "clarify" the rule for subsequent cases. In order to advance that argument, the Petitioners contend that the line of cases exemplified by Public Employees Ret. System v. Betts, 492 U.S. 158 (1989) ("Betts") creates this conflict.

In Betts a disability retiree invoked a prohibition against age based discrimination under ERISA against a public employees retirement system which had insured her pursuant to a plan that pre-dated the discrimination provision. The critical question

was whether the plan was a "subterfuge" to avoid the prohibition. The retiree argued that certain statements by a house committee and by influential members of the Congress demonstrated its interpretation of "subterfuge" was appropriate.

> This Court disagreed, commenting:
> "We have observed on more than one occasion that the interpretation given by one Congress (or a committee or Member thereof) to an earlier statute is of little assistance in discerning the meaning of that statute. (citations omitted) (Id. at 168.)

In Betts and the others cited by Petitioners, Congress does not act as a whole in enacting a specific clarification of a statute. It makes sense that whether Congress is ambivalent whether a clarification is intended (Gwaltney v. Chesapeake Bay Foundation, 484 U.S. 49, 63 n.4 (1988); ; South Dakota v. Yankton Sioux Tribe -- U.S.--, 118 S.Ct. 789 (1998)) when a house committee or a member of Congress purports to speak about past Congressional intent (Mackey v. Lanier Collection Agency & Serv., 486 U.S. 825, 839-840), that "little" assistance is rendered. However, when Congress amends the substantive statute in such a fashion that it unequivocally signals that it is clarifying what has been a statute subject to different interpretations, it makes sense that this Court should invoke that "venerable" rule of statutory construction that the judiciary should give Congress' enactment "heavy weight."

In summary, then, there is really no conflict between the two principles.

5. Beverly and Paramount determined that the statutory role given to section 1396a(n) scheme was ambiguous and therefore weight should be given to the clarification by Congress.

As variation on the Petitioners' attempt to see a conflict where none exists, the Petitioners argue that the Ninth Circuit and the court in Paramount should have first done a detailed analysis of the statutory scheme to demonstrate there was an ambiguity for which clarification was necessary (e.g., "the Ninth Circuit's decision failed to independently determine for itself either the meaning and intent of the 1986 QMB amendments or whether § 4714...was in any way a tenable reading of the legislation." (California Ambulance Ass'n at 21.)

What the Ninth Circuit did was to point out that various opinions had used different approaches to the proper interpretation of the statute, that the proper intent was not clear, and that section 1396a(n) was a baffling statutory provision. The Petitioners can not concede it was unclear how section 1396a(n) fit into Congress' scheme for providing benefits to QMBs. Once they make that concession, Chevron kicks in and they are lost. In any event, the Court did conclude that section 4714 was a tenable clarification of section 1396a(n) and that deference should be shown to Congress.

In Paramount, the court reached the same conclusion. Both circuit opinions must be read as agreeing that section 1396a(n) is puzzling and therefore they fulfilled whatever responsibility the Petitioners would impose upon them regarding the interpretation of

section 1396a(n). Consequently, the Petitioners do not establish that the circuit opinions lacked any condition precedent to their deference to Congress' clarification of the controversy.

6. Klein is not a ground for review under the facts of these actions.

The Petitioners' citation of United States v. Klein, 80 U.S. 128 (1872) as a basis for review is mystifying. The argument appears to be that Klein is relevant because section 4714 represents a "rule of decision" passed by Congress designed to intrude into the judicial province. The Petitioners then raise the specter of an Article III dilemma allegedly represented by section 4714 so that this Court will have the "...opportunity to provide direction to the lower courts by clarifying the scope of Klein." (Beverly pet. at 23.)

The Beverly decision does not mention the issue. Judge Posner talks about it in Paramount but never thought it sufficiently important to resolve the issue. That is easy to see why. In Klein Congress specifically attempted to change the law retroactively to avoid a decision of this Court, intruding into the powers reserved to the judiciary by Article III. Section 4714 does not represent a rule of decision. It is a clarification of the law that was in dispute. The rule of this Court is that when Congress provides clarification the judiciary gives great or little weight to that clarification depending upon the circumstances of the clarification. The Klein issue is simply not presented by this action.

The Petitioners harp on the argument that Congress enacted section 4714 in order to "decide the

controversy in [its] favor," quoting United States v. Sioux Nation, 448 U.S. 371, 404, 100 S. Ct. 2716, 2735-36, 65 L.Ed 2d 844 (1980) as somehow relevant. Unquestionably, Congress had the authority to decide the controversy in its favor prospectively by amending the statute. (Plant v. Spendthrift Farm, Inc, 514 U.S. 211, 218 (1995). In that sense, Congress decided the controversy in favor of the Secretary and the state. In Sioux Nation, this Court discussed Klein but did not reach the Klein issue. Accordingly, it is hard to see how Sioux Nation adds anything to the Petitioners' case. Moreover, when Congress enacts a clarification, by the nature of a clarification Congress is attempting to direct the outcome in a fashion Congress perceives to be in its "favor."

Finally, Congress did not attempt to impose a rule of decision upon the four circuits in which the courts - erroneously - held against the Secretary. The scope of its clarification only went to those circuits in which no provider had received any vested right by a final judicial decision. Accordingly, Congress never crossed over the separation of powers between the legislature and the judiciary.

7. No provider in California was promised payment by the state for crossover claims at 100% of what Medicare Providers charge.

This issue can not be reached by this Court unless it resolves the underlying dispute whether section 1396a(n) - pre-BBA - provided flexibility to the states to set the payment levels for Part A and Part B services below the Medicare charge levels for crossover claims.

In any event, from the perspective of California, this issue is contrived.

The Petitioners argue that "It is fundamentally unfair and constitutionally infirm for Congress to tell a provider who has been promised $100 to provide a service, that after providing the service, the rate has been changed after the fact to $80." (California Ambulance Ass'n at 30.)[2] No provider in California was under the illusion that it was promised $100 and then paid $80. Under Samuel, since 1983 all providers were on notice that California paid the Medicaid level of payment - not the Medicare level of what the providers charged.

In California, the relationship between the providers and California is a contract. (California Medical Assn. v. Lackner, 117 Cal.App. 3d 552, 560 (1981).) In California, "A statute fixing government payments may amount to an offer which, when accepted by performance, culminates in a contract between the government and the offeree." (internal quotation marks removed.) (Ibid.) Under this theory, Lackner held that the regulations - which are authorized by statute - of the Department constituted an offer and the providers acceptance of that offer - by providing services - constituted an implied contract. (Id. at 561.)

---

2. The amicus brief filed by the American Medical Association argues that 4714 is unconstitutional under Eastern Enterprises v. Apfel, -- U.S. --, 118 S.Ct. 2131 (1998), contending that "the law's effect depends solely upon the confiscation of [physician's vested rights to payment under the prior statutory scheme]." (AMA Brief at 11.) Yet, in California the reasonable expectation of physicians was that they would be paid at the Medicaid rate. Consequently, Eastern Enterprises - aside from the fact the facts of the case have no resemblance to those of this action - does not apply.

Welfare and Institutions Code section 14109.5 clearly expressed the California policy - offer if you will - to providers that they would not be reimbursed at the rates they charged pursuant to Medicare for crossover claims. Consequently, no California provider of Part A or Part B services was promised $100 as the Petitioners claim.

CONCLUSION

The petitions should be denied. "[Section 1396a(n)] has shown itself to be particularly resistant to a single simple interpretation, and hence particularly in need of clarification." Beverly at 1266).

Dated: August 28, 1998

Respectfully submitted,

DANIEL E. LUNGREN
Attorney General of the State of California

CHARLTON G. HOLLAND, III
Senior Assistant Attorney General
Counsel of Record

Counsel for State Respondent

APPENDIX A

§ 14109. Determination of medical needs; inclusion of cost of deductibles or cost sharing charge

In determining the medical needs of any person eligible under this chapter, and the amount of health care such person is entitled to receive, the department shall include the cost of any deductibles or, cost sharing or similar charge imposed in connection with benefits to which such person may be entitled under the federal program of health insurance for the aged and disabled, except that for those individuals 65 years of age or over, who prior to July 1, 1973, were ineligible under the federal program of health insurance for the aged, the director may include such costs.

§ 14109.5. (1982) Limitation on reimbursement rate notwithstanding inclusion of cost of deductibles or cost sharing charge; change orders, expeditious implementation

Notwithstanding the provisions of Section 14109, effective January 1, 1982, the reimbursement rate for costs specified in Section 14109 shall, to the extent feasible, not exceed the reimbursement rate for similar services established under this chapter.

The fiscal intermediary shall expedite the implementation of any change order resulting only from this section. The department shall provide sufficient funding for any such change order to enable the fiscal intermediary to implement such change order expeditiously and to not have to divert staff or other resources from existing contract tasks, including but not limited to those resources dedicated to the implementation of all other change orders.